

# **KANSAS RYAN WHITE TITLE II CASE MANAGEMENT STANDARDS OF CARE**



PUBLISHED SEPTEMBER 1999

REVISED OCTOBER 2002

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## INTRODUCTION

The original Standards of Care for the State of Kansas were published in 1999 and were created using the Standards of Care for the Ryan White Program of the State of Michigan. With the permission of the State of Michigan program in 1999, the Kansas development committee made adjustments to the Michigan standards to reflect the scope of service needs in Kansas. The current document has been revised to reflect current trends in providing case management services in rural areas. Consideration for revision contains input from providers and policy makers. Additional resources

utilized to revise this document that contain data specifically relevant to the State of Kansas include: Kansas Ryan White Title II Statewide Needs Assessment (1999, 2001) and the Kansas Department of Health and Environment's Contracted Case Management Site Visit Reports (2002). General resources include Ryan White CARE Act, Health Resources and Human Administration (HRSA) Program Principles 1997. Title II Standards of Care reviewed from other states include: Pennsylvania, Oregon, Wisconsin, Massachusetts, and Northern Nevada.

## PURPOSE

This document is designed to recognize and build upon the diverse approaches taken in case management throughout rural areas in the State of Kansas. The ongoing development and review of this document is maintained through a collaborative effort of providers and policymakers who come together to ensure the standards of service contained herein meet the needs of persons living with HIV/AIDS.

The standards are a comprehensive statement of the expectations of case management services on a statewide basis. They also serve as framework for evaluating the practice of HIV/AIDS case management and define the case manager's

accountability to the public as well as their clients. The design of this document is to reflect the current needs of providers and the clients they serve.

All of the participants involved in creating this document agreed it should be viewed as a constructive, non-punitive mechanism for improving the quality and consistency of case management services throughout the State of Kansas. To insure its continued relevance, this document will be reviewed annually by a workgroup convened by the Kansas Department of Health and Environment (KDHE) and resembling the one described above.

**All of the provisions found in this document apply to agencies contractually obligated to comply with the standards, regardless of funding source. In cases where KDHE is not the primary funding source of an agency that provides HIV/AIDS Case Management Services under Contract #33, neither the consortia or KDHE shall bear the financial costs of objective review, nor shall KDHE function as the lead facilitator of the objective review process.**

## **HIV/AIDS CASE MANAGEMENT in KANSAS : An Overview**

Early HIV/AIDS Case Management was focused primarily with coordinating support services for a terminally ill population by providing support to assist people with AIDS and their families, partners, and loved ones as they coped with a disease that resulted in death. The primary function of this type of case management was coordinating and obtaining psychosocial support services. Models of nursing case management and medical case management specific to AIDS were only beginning to emerge during these early stages of the epidemic.

In 1991, The Ryan White CARE Act supported HIV/AIDS Case Management as a core component in the proper delivery of HIV/AIDS services. The act also mandated case management in rural communities under Title II. Case management services developed into a link between medical and social support services. This resulted in large amounts of available funding for AIDS Service Organizations, Community-Based Organizations, and Local Health Departments to provide case management services as well as other needed wrap around services. Due to the evolving design of the service delivery system, HIV Case Managers often manage support services they traditionally refer clients to. The traditional scope of services the HIV Case Manager provides often becomes secondary to managing wrap around services.

Case management in rural service areas tend to be limited to psychosocial support due to a noted lack of medical services, social support networks, inadequate transportation, greater distance to travel for services, and the overall lack or presence of specialty services or expertise in the immediate service area. However, case management services in rural areas of Kansas have made successful strides in overcoming these barriers by establishing linkages between specialty medical providers for outreach clinics, other community-based organizations, health clinics, and local health departments.

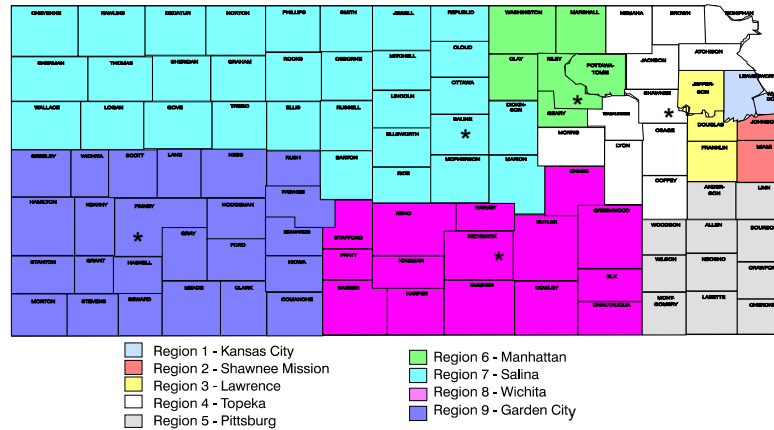
The rural case management system provides a designated case manager who is responsible for all HIV services. The case manager will perform an intake and standard eligibility that will include triage to determine urgent needs of the client. The full assessment is usually scheduled at a later date. Clients are self-referred, or have been referred for services by DIS, medical provider, family member, or other agency. Due to large distances and geographic locale of case management office, visits may be conducted at home or at safe neutral sites designated by the client.

Case management services provided to clients in Kansas have a stronger link to medical care and wrap around services, resulting in an improved quality of life. Case managers are dealing with changes in the overall demographics of the population served, including issues on culture, gender, impact of mental health and substance issues on treatment plans, women and children, and people affected by poverty and homelessness.

In maintaining a continuum of care for clients, health education and risk reduction activities were provided in addition to the medical, nursing, psychosocial, and social work aspects of the HIV case management services in Kansas. The focus began shifting from providing short-term immediate services resulting in death to chronic disease management while empowering clients to achieve an improved quality of life.

The State of Kansas also shifted its focus of case management services by designing regional divisions throughout the state. These “regions” offered client’s access to case management services without the intensive travel necessary to reach more populated areas where care and treatment were more established.

Below are the regional divisions that the KDHE identifies throughout the state. As of September 2002, the Ryan White Title II CARE Program enrolled 693 Kansans in care services throughout the state. This is 23% increase since February 2001 (n=532). Enrollment into care services allows the client to access home health, mental health, dental care, primary care, insurance assistance, AIDS drug assistance through the statewide ADAP, and case management services. The chart below reflects the numbers (percentages) of those clients currently enrolled in care services.



Reported numbers (%) as of September 2002									
	Statewide	Regions 1-2	Regions 3	Regions 4	Region 5	Region 6	Region 7	Region 8	Region 9
<b>Enrolled</b>	693	126 (18%)	22 (3%)	81 (12%)	31 (4%)	27 (4%)	44 (6%)	329 (47%)	33 (5%)
<b>Accessed Title II – All Services*</b>	525	97 (18%)	16 (13%)	55 (10%)	27 (5%)	15 (3%)	34 (6%)	256 (49%)	25 (5%)
<b>ADAP Only</b>	434	96 (22%)	14 (3%)	44 (10%)	16 (4%)	12 (3%)	27 (6%)	206 (47%)	21 (5%)
*This does not include those clients receiving case management services and not enrolled in the Kansas Ryan White Title II CARE Program.									

## **A STATEMENT of PRINCIPLES for CASE MANAGEMENT**

Workgroups of people living with HIV/AIDS and Ryan White Title II Case Managers of Kansas prepared the following statements of principles or rights and responsibilities for the consideration and guidance of providers of case management services. These statements serve as an outline of the kind of expectations held by people living with HIV/AIDS and therefore represent an invaluable resource to providers as they seek to center their services on the needs of their clients. Reflecting the concerns often felt most acutely by those participating in this process, these statements are presented here in the order generated by the workgroup, bearing no significance of ranking beyond that fact.

1. Clients and case managers will treat each other with mutual respect and dignity in all interactions. Inappropriate behavior will not be tolerated by either party. Inappropriate behavior can be defined as, but not limited to, physical violence, verbal abuse, and sexual inappropriateness.
2. When clients or their representative(s) contact a provider, the case manager needs to respond in a timely manner by telephone, mail, or other advocacy. When the assigned provider is not available, a designated back up should be provided.
3. Clients have the right to regular contact from case managers (at least in keeping with the standards advocated in this document). Clients agree to notify their case manager of any changes in their status.
4. A grievance or appeal process will be available if clients are dissatisfied with services.
5. All clients have the right to a Kansas Ryan White Title II brochure of client rights and responsibilities, information about the Americans with Disabilities Act (ADA), as well as a listing of available services and a statement of non-discrimination.
6. A case manager's role is to provide assistance and coordination of resources to enhance the autonomy of the client.
7. All activities of case management will be conducted in accordance with the confidentiality guidelines outlined in this manual.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

## STANDARDS of HIV/AIDS CASE MANAGEMENT SERVICE

Case management is an approach to non-emergent HIV-related service delivery that is client-centered and community-minded. Case management is comprehensive in scope and provides a means to enhance the quality of life for people affected by HIV. While functioning under a specific professional scope of service, ethics, and standards, case management is a system of need and utilization assessment that helps local communities plan and allocate resources.

Case management assesses the needs of the client, their family and social support system. Based upon the assessment, case managers arrange, coordinate, monitor, evaluate, and advocate for a variety of services centered to meet the clients needs.

There are fundamental components common to all effective models of case management. These components include:

- *Intake*
- *Acuity scale*
- *Reassessment*
- *Personal case plan implementation and monitoring,*
- *Assessment*
- *Personal case plan development*
- *Discharge*

Other case management activities may include:

- *Outreach*
- *Health Education/Risk Reduction (HE/RR)*

Additionally, all models of case management should reflect principles of service delivery which affirm a clients right to:

- *A quality life*
- *Confidentiality*
- *Nondiscrimination*
- *Culturally competent service*
- *Privacy*
- *Self-determination*
- *Compassion*
- *Dignity and respect*

### **Continuous Quality Improvement (CQI):**

#### **Ryan White Title II Program Requirement for Chart Audits**

*All individuals with HIV/AIDS determined eligible and who access any Ryan White Title II funded service must have an intake and acuity scale that serves as the client's annual assessment unless otherwise indicated.*

The remainder of this section will provide an overview of key provisions of the components of case management.

## **KEY PROVISIONS : An Overview**

### **Confidentiality**

All written and verbal communications pertaining to individual clients shall be maintained in strict confidentiality according to a written policy approved by the case management agency and statutes set forth in K.S.A. 28-1-26.

All authorized persons with access to client information shall receive routine training on confidentiality, the proper exchange of information, and required consent, and will adhere to appropriate federal laws, Kansas Laws, KDHE policies, agency policies, and appropriate licensing board policies, regarding release of information with written consent. (Refer to Appendix A: State of Kansas Statutes and regulations related to HIV/AIDS).

### **Client Record**

Agencies should provide an appropriate storage system for client files (hard copy). The system should include, at minimum, charts which securely hold and organize materials and which are secured from access by unauthorized persons under a double lock system.

### **Automated Client Files/Information**

Agencies storing client information on computer hard drive, floppy disk, or other automated systems must-ensure that:

- access is blocked by a security code and limited to authorized staff cleared for use
- systems using modems have pertinent software installed that will ensure modems and networks are blocked from any access other than the authorized users
- proper backup procedures for critical client information are systematically followed and performed at least weekly

### **Transporting Client Records and Information**

Client records and information, which are transported outside the agency, should be handled in a manner, which ensures security, and confidentiality (i.e., never left unattended, transported in a locked briefcase), which does not disclose client-specific information, and handled only by authorized persons.

Client records which are transported through the US mail system or commercial carrier should be securely packaged, marked "CONFIDENTIAL" on the face of the package, and shipped at a rate comparable to first class mail, or at a rate which ensures faster delivery.

Client information transmitted through a facsimile (FAX) machine should be done under mutually defined conditions that ensure that strict confidentiality is maintained by the agencies and/or persons sending and receiving the client information.

## **Access to Data**

Access to confidential materials (electronic files and hard-copy files) shall be restricted to authorized persons. Authorized persons are those whose responsibilities require access to specific patient/client files. For the purposes of this policy unauthorized persons are defined as visitors, or other staff who do not have access to client files as part of their responsibilities.

## **Continuous Quality Improvement (CQI)**

Case management agencies must develop continuous quality improvement (CQI) activities, which evaluate HIV case management services based on established case management standards. CQI activities may include objective review, independent chart audits, and/or other measures of program performance, which assess the quality, quantity, and outcome effectiveness of case management services. Self-reporting of agency CQI activities are encouraged and will appear on Case Management Site Visit Reports. The KDHE Ryan White Title II CARE Program Field Operations Director and/or ADAP Director before the objective review will conduct site visits annually.

Additionally, agencies must ensure the performance of an annual client satisfaction survey and may introduce additional evaluation criteria that exceed the recommendations contained herein. The KDHE Ryan White Title II CARE Program Field Operations Director will monitor whether a client satisfaction survey has been completed.

## **Components of Case Management : Intake**

### **Standard**

Each prospective client who requests or is referred for case management services will be properly screened and evaluated through a brief intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs.

### **Process**

Intake is initiated by a prospective client or his/her representative or by a third party referral (verified at least verbally by the client) to the case management agency.

The case manager with appropriate professional experience screens the service request/referral to gather necessary program information and to assess the need for immediate intervention.

Critical demographic and case specific information is collected directly or indirectly from the prospective client/referral source and the prospective client is informed of agency services and limitations.

The intake case manager will complete a universal intake and assessment form and a decision is made by the prospective client and intake staff to do one of the following:

- Open a case for the client
- Not open a case for the client, and/or
- Refer the client to an appropriate agency or service.

### **Criteria**

Within 3 working days (or 5 working days if phone contact with client is not possible) of receipt of referral or within 72 hours of client-initiated contact, the intake will be completed and an appointment for assessment scheduled. The level of crisis will be determined at time of intake and appropriate referrals made.

The person conducting the intake provides prospective client with a description of the services available from the organization, as well as services available from other agencies/organizations.

The client is informed a case management staff member will be contacting him/her to establish a mutually acceptable time to complete the assessment.

The person conducting the intake documents the disposition of the case on the intake form.

## **Documentation**

- Date of intake
- Date referral received by agency
- Client name
- Home address
- Mailing address
- Telephone/message number, if available
- HIV status per client self report
- Emergency contact information
- Communication method to be used for follow-up
- Source of referral
- Presenting problems identified by client
- Summary of initial services provided
- Individuals the provider is authorized to contact regarding client status/needs
- Signature of person completing intake

## **Verification of eligibility**

Client's self-report of HIV status is documented at intake. Within 30 working- days from the date of intake, verification of client status must be obtained. Acceptable verification includes at least one of the following:

- Copy of the clients seropositive test result, confirmed in accordance with Kansas Law;
- Signed document from a physician or his/her designee (as allowed under Kansas Law), verifying that the client is HIV positive;
- Lab results at any time during the client's lifetime that shows the presence of the human immunodeficiency virus; or
- Ryan White Title II medical eligibility form completed and signed by physician.

Exemption from the requirement to secure verification of HIV status is granted when a person who is affected, but not infected, is determined to be appropriate for case management services. However, as per HRSA guidelines, if case management services are provided to a client who is affected, but not infected, there must be clear rationale documented in the client file that the services offered will directly benefit a person living with HIV/AIDS. Specifically, rationale will address one or more of the following:

- How the delivery of case management services to the affected client will allow him/her to participate in the care of someone with HIV disease or AIDS;
- How case management of the affected client will enable an infected individual to receive needed medical, support or housing-related services by removing an identified barrier to care;
- How case management of the affected client will promote family stability in coping with the unique challenges posed by HIV/AIDS

## **Components of Case Management : Assessment**

### **Standard**

Each client of case management services will participate in at least one (1) face-to-face interview to assess his or her biopsychosocial needs.

An assessment is an information gathering process, which includes a face-to-face interview between a client and case manager and acquisition of secondary data from health and human service professionals and other individuals. It is a cooperative and interactive process during which a client and case manager collect, analyze, synthesize and prioritize information which identifies client needs, resources, and strengths for purposes of developing a service plan.

#### **Assessment Identifiers:**

1. The extent and nature of client needs
2. The capacity of the client to meet personal needs
3. The capacity of the client social network to address client needs
4. The capacity of available human service agencies/organizations to address client needs

Assessment is directed at reaching mutual agreement between the case manager and client concerning priority needs and client strengths and limitations.

### **Process**

Assessment is conducted by case managers and is performed in accordance with written policies and procedures established by each respective agency and in compliance with the guidelines set forth by KDHE. Other individuals with appropriate professional experience may assist the case manager in the assessment process, provided client consent has been obtained.

The face-to-face interview is conducted at a site mutually acceptable to the client and case manager. Assessments are conducted in the client's home whenever possible, with the client's consent.

The process of identifying client needs and strengths should be a participatory activity, which involves client self-assessment and supports client self-determination. Equally important is ongoing collaboration between the case manager and other health and human service providers and individuals involved with the client.

### **Criteria**

After an intake determines a case should be opened; the designated case manager conducts an assessment by utilizing the acuity scale. The acuity scale is a comprehensive document that addresses all life areas (basic needs, medical needs, living situation, mental health, addictions, adherence, culture and language, dependants, transportation, health insurance, domestic violence, legal issues, development disabilities, support system, knowledge of HIV, risk reduction, and finances).

Within three (3) working days following intake, the client is contacted to schedule an appointment for assessment. The client assessment is conducted, utilizing the acuity scale, in face-to-face meetings between the client and case manager, commencing no later than seven (7) working days following intake unless client's status dictates otherwise and rationale is documented in the client record.

Client needs are systematically assessed and documented. This involves the active participation of the client, health and human service professionals, and other individuals, as agreed to by client. Client needs should be identified in the following areas:

- Income
- Financial resources (identification of and coordination with insurance, veterans benefits, and other sources of financial assistance)
- Housing/shelter (residential support, adaptive equipment and assistance with decision making)
- Employment
- Educational status and daily structure, if appropriate (prognosis for employment; education/vocational needs; appropriateness and/or availability of educational, rehabilitation and vocational programs)
- Physical and dental health status, considerations of potential for rehabilitation
- Mental health and emotional status
- Cultural, ethnic, or racial considerations
- Communication skills, literacy, and/or translation requirements
- Social status and skills
- Social relationships and support (informal care givers; formal service providers; significant issues in relationships, social environments)
- Clients physical environment, questions regarding mobility in home and accessibility
- Recreation and leisure
- Activities of daily living
- Transportation
- Legal status, if appropriate (guardian relationships, involvement with the legal system)
- Spirituality/religion
- Self-care knowledge, assets, and limitations including HIV transmission, risk reduction strategies
- Accessibility of community resources which the recipient needs or wants
- Assessment of alcohol, tobacco and other drug use and misuse
- Knowledge of legal rights and responsibilities regarding ADA and other pertinent HIV/AIDS law

The client is informed of his/her rights and responsibilities in case management (this includes providing the client with a copy of the Statement of Principles (See Page 6)). The case manager and client should sign a copy of the Standards of Principles. The original should be given to the client and a copy should be filed in the client's case management chart. The client is also provided information on local community services, including a directory, if available.

### **Documentation**

- Clients written consent to be served (dated and signed)
- Appropriate release(s) of information (dated and signed)
- Key personal data and any data not collected with intake or that has changed since intake
- Biopsychosocial assessments utilizing the acuity scale conducted face-to-face with the case manager.
- The acuity scale must be updated annually or according to the client's level of acuity.

## Acuity Scale Instructions

### **Goals**

The acuity scale is a tool for the case managers to use in lieu of the customary professional, needs-based assessment interview. It's intent is to provide a framework for documenting important assessment elements and standardizing the key questions that should be asked as part of a professional assessment.

The acuity scale also helps provide consistency from client to client assisting in an objective assessment of a client's need, thereby minimizing inherent subjective bias. This scale also translates the assessment into a level of programmatic support designed to provide the client assistance appropriate to their assessed need and functioning.

### **Instructions for use**

The Acuity Scale has variable point scoring built into it so that it provides more points for "Life Areas." These Life Areas assess activities potentially disabling to a client and therefore have greater priority when developing a personalized care plan and assigning program support activities. Not all Life Areas have the same point values assigned to them.

1. Interview the client following the Standards of Care.
2. Review all pertinent client documents, secondary assessments done by other professionals (if appropriate) and any relevant information available about the client's needs.
3. Check the appropriate indicators in each Life Area on the Acuity Scale.
4. Using your professional judgment, assign a Life Area for each category. If there are indicators which are so compelling that they are potentially disabling to a client, a higher stage of Life Area may be assigned to that category so that higher levels of program support may be provided to stabilize the client.
5. The score is assigned based on the number indicated at the top of each "Stage". It is not based on the number of indicators within that Stage.
6. Points should be calculated at the end of the Acuity Scale Worksheet. The total score indicates the level of acuity for the client. Stages 1 and 2 are Basic, Stage 3 is Intermediate, and Stage 4 is Intensive. Appropriate case management activities and development of personal care plan are then assigned according to indicated acuity scale.

## Acuity Stage Indicators

<b>Basic</b>	<b>Stage 1</b>	<b>17-20 points</b>	<ul style="list-style-type: none"><li>▪ Case management intake,</li><li>▪ Minimum telephone contact every 3 months to verify address/phone number and to check on the client's current status; and</li><li>▪ Documentation in progress notes.</li></ul>
<b>Basic</b>	<b>Stage</b>	<b>221-34 points</b>	<ul style="list-style-type: none"><li>▪ Initial Assessment.,</li><li>▪ Annual re-assessment;</li><li>▪ Minimum contact (telephone or face-to-face) every 3 months; and</li><li>▪ Documentation in progress notes or care plan as indicated.</li></ul>
<b>Intermediate</b>	<b>Stage 3</b>	<b>35-70 points</b>	<ul style="list-style-type: none"><li>▪ Initial Assessment,</li><li>▪ Minimum 6 month re-assessments;</li><li>▪ Minimum contact (telephone or face-to-face) every 30 days;</li><li>▪ Minimum evaluation of care plan every 30 days; and</li><li>▪ Documentation in progress notes and care plan.</li></ul>
<b>Severe</b>	<b>Stage 4</b>	<b>71-102 points</b>	<ul style="list-style-type: none"><li>▪ Initial Assessment,</li><li>▪ Minimum 6 month re-assessments;</li><li>▪ Minimum contact (telephone or face-to-face) every 2 weeks;</li><li>▪ Minimum evaluation of care plan every 2 weeks; and</li><li>▪ Documentation in progress notes and care plan.</li></ul>

## **Components of Case Management : Personal Case Plan Development**

### **Standard**

A personal case plan will be developed in an interactive process with each client of case management services.

The client personal case plan is a case management work plan, which systematically identifies agreed upon client needs based on a comprehensive client assessment. The universal Case Plan Worksheet shall be completed and utilized by the case manager and the client.

The purpose of the personal case plan is to facilitate client access to services and to enhance coordination of care. The personal case plan also ensures case management accountability.

Development of the client personal case plan is an interactive process between the case manager and the client. It is a process which supports client self-determination whenever possible and empowers a client to actively participate in the planning and delivery of services. Under certain circumstances (e.g., client neurological impairments, crisis situations, etc.), decision-making may be deferred to a representative legally designated by the client, with the case manager serving as an adviser. It is the professional responsibility of the case manager to analyze needs and to discuss service plan alternatives with the client. This includes a discussion of anticipated outcomes or consequences in choosing alternatives for the personal case plan.

The role of the case manager is primarily one of resource coordination and advocacy. The service function of case management is to facilitate access to those services critical to obtain optimal health and well being for the client and to help solve problems necessary when barriers impede access.

When, during service plan development, specific knowledge and/or skills are needed beyond those of the case manager; consultation with other professionals is sought with appropriate releases of information. The case manager documents this in the client record.

The service plan is structured, documented, time-specific and ongoing. It specifies the method of measurement and provides the basis for determining the effectiveness of case management and the rationale for the purchase of or referral for services.

### **Process**

Service plan development is conducted by case managers in coordination with the client and is performed in accordance with written policies and procedures established by each respective agency and KDHE. After completing the assessment, the case manager and client develop a list of priority needs related to obtaining and maintaining optimal health and well being for the client.

The personal case plan is developed to:

- Prioritize client needs to be met through case management
- Establish measurable short and long-term goals
- Establish objectives and action steps to meet service plan goals
- Identify formal and informal resources to accomplish goals
- Identify gaps and overlays in services
- Identify alternatives to meet client needs

The case manager and client review authorize and implement the personal case plan and, adjust as needed.

The client or his/her representative is informed of and agrees to assume responsibility for notifying the case manager about changes in the client's status or significant problems encountered in receiving needed services.

## **Criteria**

Within ten (10) working days following assessment, a personal case plan is established by the designated case manager and recorded in the client record. The case manager and client review, authorize and implement the service plan within a reasonable period of time and, adjust as needed. Thereafter, all service plans are reviewed and renewed at a minimum of once every quarter, or more often as needs change, and are documented by the assigned case manager.

The personal case plan will identify who is responsible for contact and follow-up with the referral source upon initiation of service. All personal case plans should be developed in accordance with client preference whenever possible.

If service requirements are greater than resource availability, priority shall be given to clients who fall under the following criteria:

- Need protective services
- Living in an unstable environment
- Unstable medical or psychological conditions

## **Documentation**

The universal personal case plan form is to be used as documentation. The personal case plan, signed and dated by the case manager, should include the following:

- The strengths of the client;
- Description of the problem(s);
- Description of what is to be done (i.e., the solution);
- List of all formal and informal services to address the identified problem(s); and
- The quantity, frequency, time frame, and provider of service including a brief description of problem solving methods.

Notations of service plan changes should be signed and dated by the case manager and client. The client should receive a copy of the personal case plan once it has been signed and completed, including any changes that become relevant to plans success.

## **Components of Case Management : Service Plan Monitoring and Evaluation**

### **Standard**

Each client receiving case management services will have his or her needs and status monitored on-a regular basis.

Monitoring is an ongoing process, which ensures services are provided consistent with the case management personal case plan and client needs are being addressed and resolved as appropriate. The frequency of monitoring beyond a minimum of once a quarter is dependent on the level and intensity of client need. Monitoring is designed to accomplish the following:

- Evaluation of the effectiveness and relevance of the personal case plan.
- Evaluation of the level of client satisfaction.
- Measurement of client progress.
- Determination of the need for service plans revision.
- Success in meeting service plan goals and objectives and assessment of need to continue case management services.

### **Process**

Monitoring is conducted through:

- Direct contact (i.e., face-to-face meetings and telephone communication) with the client and/or his/her representative.
- Indirect contact with the client through clients family and/or his/her representative, health providers, other human service providers, etc., through meetings, telephone communications, written reports and letters, review of client records and related materials, and through client or agency staffing all conducted with client consent.

The case manager obtains information on an ongoing basis to assess/evaluate:

- Status of the client and family with regard to health and progress toward service plan goals and objectives.
- Satisfaction of client and/or client-identified caregiver with services.
- Quality and appropriateness of services provided.
- The client and/or client-identified care giver/representative is counseled about changes in the client's status or significant problems encountered in receiving needed services.

### **Criteria**

Within one quarter following development of the service plan, or a modification of that plan (i.e., after the client has signed the plan), direct client contact is made by the case manager for purposes of monitoring the client's progress and evaluating the effectiveness of the service plan. Client request and rationale for less or more frequent contact are documented in the client's record and respected, whenever possible.

Monitoring should be conducted by the case manager or by a person designated by the case manager with relevant HIV-related case management experience.

Clients are surveyed annually, at a minimum, to assess satisfaction with case management services and services coordinated under case management.

## **Documentation**

The client record includes ongoing documentation, signed and dated by the case manager, of the following:

- All client contacts
- All contacts with the clients support system, providers and other participants
- Changes in client status
- Progress made towards personal case plan

## **Components of Case Management : Reassessment**

### **Standard**

At least annually, each client receiving case management services will have their needs reevaluated through a comprehensive biopsychosocial reassessment.

Clients are reassessed through a comprehensive assessment process, which determines the client's current case management status and the need for revisions in the service plan. Reassessment is conducted in the event of significant changes in the client's life or at a minimum of every 6 months.

### **Process**

Reassessment is conducted by the case manager and is performed according to established standards and criteria. The process of reassessment should encourage active participation by the client and/or significant other. The process of reassessment may involve the collaboration between the case manager and other health and human service providers, individuals actively involved with the client, and through client record review.

### **Criteria**

Active case managed clients will be reassessed in the event of significant changes in the client's life or at a minimum of annually.

Reassessment will include but not be limited to the original assessment areas and include service plan progress, changes, and mutually agreed upon goals.

### **Documentation**

- Updated summary of key personal data
- Reassessment summary
- Updated problem list
- Updated biopsychosocial assessment conducted face-to-face with the client
- Updated service plan reflecting the above input and review

## **Components of Case Management : Discharge**

### **Standard**

A systematic process shall be in place to guide discharge from case management services and allow for client appeal of discharge decisions.

A client will be placed on inactive status after a no-contact period of one year, but will continue receiving mailings for another year at which point the case will be closed. The client may contact the agency at anytime to re-activate or re-open the case.

### **Process**

The following protocol will be used when a case is **closed due to ineligibility**:

- Case manager will report to supervisor, where appropriate and KDHE, the client's situation, actions, behavior (verbal and/or nonverbal) that makes the client ineligible for case management services;
- Case manager notifies his/her supervisor, where appropriate, and KDHE of intent to discharge client (Supervisory involvement on final determination of discharge takes place when discharge is initiated by the agency);
- Case manager makes attempt to notify the client (through face-to-face meeting, telephone conversation or a certified letter) of plan to discharge client from case management services and reason for discharge;
- Client receives written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the reasons for discharge;
- Case manager completes the discharge summary and it is reviewed and signed by case management supervisor, where appropriate and a copy sent to KDHE;

The following protocol will be used when a case is **closed at the clients or client and guardians request**:

- If the client so desires, appropriate referrals will be made on the client's behalf, with appropriate consents, if client so desires;
- Case manager will notify and verify termination of all funded or arranged services and it is reviewed and signed by case manager supervisor, where appropriate, and a copy sent to KDHE.

The following protocol will be used when a case is **closed due to client death**:

- Client's family, significant other, direct care provider, legal guardian, or other designated person approved by the client should notify the case manager of the client's death;
- Appropriate referrals are made for family and significant others, i.e., grief counseling, support services, etc.;
- Case manager will notify and verify termination of all services arranged by the case manager and will complete billing requirements, if appropriate;
- Case manager completes the discharge summary and it is reviewed and signed by the case manager supervisor, where appropriate, and a copy sent to KDHE.

## **Criteria**

Reasons for client discharge include:

- Client relocation outside of agency service area
- Case management problems completely resolved
- HIV seronegative status
- Noncompliance with service plan
- Inability to contact client
- Client decision to terminate services
- Abuse of agency staff, property or services
- Death

Date of discharge is established by the following:

- Date of death
- Date agency and client or guardian agree on termination of services
- Date agency determines and documents client ineligibility for case management services

*In the event of clients' death, follow-up case management services may be offered to the family/significant other(s) for six (6) months.*

Within four (4) weeks of the final decision to terminate services, a discharge summary universal form is prepared and signed by the case manager, reviewed and countersigned by the case management supervisor, where appropriate, and placed in the clients record.

Client records are stored and retrievable by the agency for a period following discharge as required by applicable law and/or agency policy.

## **Documentation**

- Reason(s) for discharge; and
- Formal client notification of case closure and appeal process when client becomes ineligible for service, when possible.

## **CONTINUOUS QUALITY IMPROVEMENT (CQI)**

### **INTRODUCTION**

The standards found in this document are intended to guide the delivery of case management services to all persons living with HIV/AIDS in the state of Kansas. Therefore, a standardized approach to evaluating case management services based on these standards is critical to establishing reliability of results and the ability to accurately measure compliance. To promote and support standardization of this

process, the KDHE Ryan White Title II CARE Field Operations Director will function as the lead facilitator of objective review for all case management agencies. This will encompass implementing all aspects of objective review, including use of a standardized evaluation instrument, scheduling reviews and preparing and disseminating reports on reviews.

### **CASE MANAGEMENT SITE VISITS**

Site visits are a new complementary evaluation tool in the Kansas Ryan White Title II C.A.R.E. Program's established Continuous Quality Improvement (CQI) Process. In order to assure adequate outcomes evaluation of the entire program, new quality assurance indicators will be included in process evaluation. The current CQI process ensures that the minimum standards are met. The site visit will assist in answering invaluable questions regarding process evaluation and, for example, the distinction of what services are available to clients in a specific region and what services clients are actually utilizing in that region.

Additional evaluation measures during the site visit will include a comparative analysis between the agency's overall work plan and

actual implementation. Implementation can include comparison of work plan components that operate consistently with the objectives and procedures in the Kansas Ryan White Title II Provider Manual and Standards of Care for Case Management. Consideration will be given for agency variances according to region. These variances will be accounted for in the final site visit report.

Assessment of sites by region will provide useful information as the program prepares for regional changes in the next funding year. The information gathered can also assist in addressing the quality of our services and overall client satisfaction as a participant in the C.A.R.E. Program.

### **Objectives**

- Appropriate assessment of agency priorities and available resources by region
- Identification of unique agency activities and resources by region
- Establish client profile of those served by agency (present and retrospective)
- Ensure client satisfaction surveys are current and reports of results are available
- Review Case Management Chart Audit Requirements for the objective review
- Review random sample of 5% active and 2% discharged client charts for each case manager

## **Duration**

Site visits will vary in duration due to the size of the agency and the number of case managers. There will be consideration for existing work schedules at each agency when the site visit is scheduled. It is also expected that the site visit may be interrupted due to client emergencies or other work-related situations.

## **Staff**

The KDHE Ryan White Title II CARE Field Operations Director will conduct site visits. The ADAP Director will be present for site visits as needed. Contracted case manager(s) are the only required agency staff to be present during the site visit. Agency administration and other agency staff are welcome to attend the site visit.

## **Preparation**

Once a site visit has been scheduled with an agency, the case managers will be requested to submit a memorandum identifying areas of need, for example, clarification on a specific policy and procedure or concerns regarding provision of services to clients. Case Managers are encouraged to discuss items identified with their agency administrator and/or other agency staff for additional input.

## **Site Visit Report**

Site visit reports will be available within one week of the scheduled visit. The report will contain background information about the agency and services provided topics of discussion, solutions for short-term needs, dates and timelines to address long-term needs, recommendations for program improvement, and conclusions. The report will be written in a professional manner and is intended to serve as an additional evaluation tool in meeting the standards preceding the objective review.

### ***Criteria for Site Visit Rating\****

#### **Site Visit Rating**

Good  
Fair  
Poor

#### **Level of Compliance**

Agency found in compliance with accommodations  
Agency found in compliance  
Agency found in non-compliance

\*The site visit rating is consistent with the scoring of the objective review process. However, the process of the site visit is to provide technical assistance to case managers to prepare for the objective review process. Due to this rationale, an overall score is not given.

## **Post Site Visit Evaluation**

The post site visit evaluation form will be sent to the agency with a final copy of the site visit report. The evaluation form will provide useful feedback and information to measure how successful or unsuccessful this type of evaluation is for the Kansas Ryan White Title II C.A.R.E. Program.

## **MEASURING COMPLIANCE WITH THE STANDARDS CONTINUOUS QUALITY IMPROVEMENT (CQI)**

### **Objective Review Process**

The case manager objective review will be scheduled 60-90 days after the site visit. A copy of the Case Management Audit Checklist will be provided and reviewed at the site visit. It is recommended that agencies perform a pre-audit before the objective review as a means of preparation. Requests for pre-audits from the KDHE Ryan White Title II CARE Field Operations Director and the KDHE CARE ADAP Director can be submitted in writing within 30 days of receipt of the site visit report. Requests will be accommodated based upon the availability of the KDHE Ryan White Title II CARE Field Operations Director and/or the KDHE CARE ADAP Director.

### **Objective Review Guidelines**

**The following guidelines will be used to guide implementation and facilitation of objective reviews:**

1. All case management agencies will be reviewed at least annually. KDHE will inform providers of the date of the objective review at least two weeks prior to the review. Scheduling will take into account provider preference as much as possible.
2. The KDHE Ryan White Title II CARE Field Operations Director will meet with the agency and arrange to randomly select client files for objective review.
3. The KDHE Ryan White Title II CARE Field Operations Director will review at least ten active case files, or 10% of active case files whichever is greater. Any site with less than ten active cases will have all files reviewed. Active cases are defined as any case, which has not been formally and completely closed or placed in inactive status.
4. The KDHE Ryan White Title II CARE Field Operations Director will review five randomly selected discharged files. Discharged files created prior to the full implementation of these standards of care will not be reviewed.
5. Standardized criteria, as measured by the Objective Review Checklist, will be used to determine agency compliance with the standards.
6. The KDHE Ryan White Title II CARE Field Operations Director may determine, with supportive rationale that an additional review is warranted prior to the next scheduled annual review.
7. The KDHE Ryan White Title II CARE Field Operations Director will prepare all written reports based on the findings of the review. The findings will be distributed to the agency, KDHE HIV/STD Section Director, and the ADAP Director.
8. Agencies found in compliance with all standards will be issued a memorandum stating such, along with a certificate of compliance, to be used, as the agency desires. The certificate of compliance shall be posted in an area visible to clients who receive services.
9. Agencies found to be in non-compliance will submit a remediation plan outlining the corrective action to the KDHE Ryan White Title II CARE Field Operations Director within thirty days of non-compliance notification. A follow-up review will take place approximately ninety days after receipt of the remediation plan.
10. Non-compliance by the agency with these review processes and standards of care are contractual issues to be resolved with the KDHE HIV/STD Section Director.

## Objective Review Checklist

### Section 1: General Agency Requirements

Item	TPV	PG	N/A	Comments
Case management records are stored in a double lock secured filing system	10			
Computerized records are password protected and backed up at least weekly	10			
There is a system of documenting when and by whom client files are removed from the filing system	4			
A client satisfaction survey was completed within the previous twelve months.	6			
For each client, there is a separate file maintained.	6			
Case management certification guidelines are being followed as outlined in the "Kansas Ryan White Title II Case Management Standards of Care (Rvsd 10-02)".	10			
<b>Section Totals</b>	<b>46</b>			

### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

## Objective Review Checklist

### Section 2: Intake

Item	TPV	PG	N/A	Comments
There is a completed intake in the client file	<b>6</b>			
The intake was completed within three working days of the referral or there was a rationale provided for why this did not occur.	<b>6</b>			
Immediate client needs were identified and appropriate actions taken	<b>10</b>			
Disposition of the case is documented in the client record	<b>4</b>			
<b>Section Totals</b>	<b>26</b>			

### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

## Objective Review Checklist

### Section 3: General File Requirements

Item	TPV	PG	N/A	Comments
The client record contains a signed and appropriately dated consent to serve	<b>10</b>			
The consent to serve describes the case management services offered at the agency, client rights and responsibilities and where and how the client is to be contacted.	<b>6</b>			
Releases of information were obtained for all providers, family members and others with whom information about the client is shared.	<b>10</b>			
There is verification of eligibility in the file.	<b>10</b>			
All papers are secured within the file.	<b>4</b>			
All entries in the client record are recorded in ink	<b>4</b>			
<b>Section Total</b>	<b>44</b>			

#### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

## Objective Review Checklist

### Section 4: Assessment

Item	TPV	PG	N/A	Comments
There is a biopsychosocial assessment, utilizing the acuity scale, in the client file.	<b>6</b>			
There is documentation indicating the client was contacted within three working days of the intake to schedule an assessment or there was documented rationale as to why this did not occur.	<b>6</b>			
The assessment was conducted within seven working days following the intake, in a face-to face meeting with the client, preferably in the client's home, or documentation as to why this did not occur.	<b>6</b>			
At minimum, the assessment addresses the following broad areas: financial status, employment history and status, medical history and status, social environment, mental health, substance use/abuse and housing information.	<b>10</b>			
The assessment includes explanations and conclusions of areas of strengths and needs.	<b>8</b>			
A face-to face meeting occurred at least every six months at which time assessment data was updated as needed.	<b>6</b>			
<b>Section Total</b>	<b>42</b>			

### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

## Objective Review Checklist

### Section 5: Personal Case Plan Development

Item	TPV	PG	N/A	Comments
An individual personal case plan is in the client file	<b>6</b>			
The initial personal case plan was developed within ten working days of the assessment.	<b>6</b>			
The personal case plan is consistent with the identified needs of the client.	<b>10</b>			
Development of the personal case plan is signed and dated by the client or their representative as evidence of participation in development of and agreement with the service plan, or there is documented rationale why this did not occur.	<b>6</b>			
Development of the personal case plan is in accordance with the documentation criteria outlined in the “Kansas Ryan White Title II Case Management Standards of Care (Rvsd 10/02)”	<b>10</b>			
The personal case plan has been reviewed at least quarterly and updated as needed.	<b>6</b>			
<b>Section Total</b>	<b>44</b>			

#### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

## Objective Review Checklist

### Section 6: Personal Case Plan Monitoring and Evaluation

Item	TPV	PG	N/A	Comments
Contacts with the client and the client's support system, providers and other participants in the personal case plan are documented in the client file.	8			
Progress made towards the personal case plan is documented in the client record.	8			
Changes in client status/needs are documented in the client record.	10			
Ongoing documentation is signed and appropriately dated by the case manager.	6			
Documentation of quarterly indirect or direct client contact for the purpose of monitoring personal case plan progress and effectiveness or attempts to contact are in the client file, or there is rationale why this did not occur.	10			
<b>Section Totals</b>	<b>42</b>			

#### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

## Objective Review Checklist

### Section 7: Discharge

Item	TPV	PG	N/A	Comments
The date and reasons for discharge are documented in the client file in the event of termination of services	8			
Services were concluded and file closed within six months of discharge, or there is a documented rationale why this did not occur.	8			
<b>Section Totals</b>	<b>16</b>			

### Calculation of Score for this Section:

TPV less NA Value = \_\_\_\_\_ Possible Points

Sum of PG divided by Possible Points = \_\_\_\_\_ Section Score

**Objective Review Checklist**  
**Scoring Sheet and Compliance Criteria**

**Agency:** \_\_\_\_\_

**Agency Contact:** \_\_\_\_\_

**Date of Review:** \_\_\_\_\_

**Reviewer:** \_\_\_\_\_

**Number of clients enrolled at agency:** \_\_\_\_\_

**Number of active files reviewed:** \_\_\_\_\_

**Number of Discharged files reviewed:** \_\_\_\_\_

**Calculation of agency score and compliance determination:**

Section 1 score x weighted value (wv) of 15	=	_____
Sum of section 2 scores divided by number of files reviewed x (wv) of 5	=	_____
Sum of section 3 scores divided by number of files reviewed x (wv) of 20	=	_____
Sum of section 4 scores divided by number of files reviewed x (wv) of 20	=	_____
Sum of section 5 scores divided by number of files reviewed x (wv) of 20	=	_____
Sum of section 6 scores divided by number of files reviewed x (wv) of 15	=	_____
Sum of section 7 scores divided by number of files reviewed x (wv) of 5	=	_____
<b>Total Agency Score</b>	=	_____

**Total Agency Score divided by 100 = \_\_\_\_\_ % for compliance determination**

**Criteria for Compliance Determination**

<u>Score Range</u>	<u>Compliance Level</u>
95% - 100%	Compliance with accommodations
75% -94%	Compliance
0% - 74%	Non-compliance

## Case Management Certification

As the front line in providing vital service linkages for people living with HIV/AIDS, case managers must be adequately and appropriately experienced and trained. While imposing a statewide standard for the type of experience required of a case manager is not feasible, training and certification of the skills and knowledge case managers must possess are both possible and desirable. To achieve this standard, the following will guide the training and certification process:

1. Minimum education and /or experience requirements of a case manager shall be:
  - An RN with BSN or Social Worker with BSW or other related health or human services degree from an accredited college or university, **or**
  - Related experience in full time service equivalent to two years regardless of education
2. All case managers must complete the current KDHE HIV/AIDS testing and counseling certification program.
3. All case managers must complete the KDHE HIV/AIDS educators certification program.
4. All case managers must complete any KDHE HIV/AIDS update trainings as provided.
5. All case managers must complete web-based evaluation training for reporting Health Education/Risk Reduction (HE/RR) individual level interventions (ILI) in order to document behavioral counseling with clients consistently statewide.
6. **The above requirements (# 1-4) must be met within one year of employment as a Ryan White Title II Case Manager.**
7. All case managers must attend all statewide mandatory case managers meeting/education updates provided by KDHE semi-annually. Exemption from this requirement must be requested in writing prior to the offering of the mandated meeting/education update and will only be given for extreme situations.
8. All case managers are expected to attend quarterly Advisory Consortium meetings unless excused absence has been provided by KDHE.
9. Case managers are required to participate in all aspects of the CQI process, including the objective review process. In order to be in compliance, case managers understand the results of their objective review must result in 75% or higher.
10. Case managers are responsible for attending monthly Case Manager Conference Calls with KDHE unless otherwise excused by the KDHE Ryan White Title II CARE Field Operations Director.
11. Case Managers will be given certification at the completion of the above criteria within one year of employment and will be re-certified annually at the beginning of the grant cycle if all certifications and updates are maintained as listed above.
12. Any agency providing case management services through contracted case managers not in compliance with the certification guidelines will be in violation of contractual agreements and must resolve the issues with the KDHE HIV/STD Director. Non-compliance could result in the termination of the case management contract provided through Kansas Ryan White Title II.

# **KANSAS RYAN WHITE TITLE II CASE MANAGEMENT STANDARDS OF CARE**

## **DEFINITIONS**

### **Advocacy**

Is the act of assisting someone in obtaining needed goods, services or benefits (such as medical, legal, social, community, or financial), especially when the individual has had difficulty obtaining services on his/her own ability. Advocacy does not include follow-up or coordination of medical treatment.

### **ADAP Director**

Kansas Title II AIDS Drug Assistance Program Director employed or contracted by KDHE for oversight of ADAP.

### **Biopsychosocial**

A comprehensive picture of a person containing information about physical, biological, psychological and social health.

### **Certification**

The minimum guidelines outlined by the “Kansas Ryan White Title II Case Management Standards of Care (Rvsd 10/02).” This is not a certification in the same way many professionals receive official, legal certification. Certification is presented on page 34.

### **Client File/Record**

A collection of printed or electronic information regarding a person using services currently or in the past.

### **Confidentiality**

Keeping private information private. Information given by a client to a service provider will not be disclosed to a third party without the express consent of the client.

### **Continuous Quality Improvement (CQI)**

A method of programmatic and service evaluation, which is designed to assure that the highest quality of services are being delivered to Ryan White Title II clients in Kansas.

### **Criteria**

Definition of a specific, measurable outcome expected from a standard.

### **Field Operations Director**

The individual employed or contracted by KDHE to manage the operations of the contracted providers throughout the state with special emphasis on provider relations, case management, and quality assurance and contract compliance.

### **Grievance**

A verbal or written complaint or concern regarding a practice or policy of an individual or organization per the organization’s policy.

### **Health Education/Risk Reduction**

Activities, which include information dissemination about methods to reduce the spread of HIV; information about disease progression; and information about the benefits of medical and psychosocial support services. This activity does not include medication or treatment information, which is part of Adherence activities.

### **KDHE**

Kansas Department of Health and Environment - The department that oversees the HIV/STD Section.

**Objective Review Process**

The quality assurance system used by Kansas Ryan White Title II to assure, as best possible, that the highest quality of services are provided to HIV/AIDS clients in case management in Kansas.

**Personal Case Plan**

The written plan directing the activities of the client and the case manager. The care personal plan delineates the case management goals and objectives required to coordinated link the client to the continuum of health and support services required to manage their disease.

**Process**

A step-by-step method to gather information or conduct an activity.

**Standard**

A rule or basis of comparison in measuring or judging capacity, quantity, content, extent, value, or quality.

**Universal Forms**

Standard forms used by all case management agencies statewide.

**KANSAS RYAN WHITE TITLE II CASE MANAGEMENT  
STANDARDS OF CARE**

**ADDITIONAL RESOURCES**